Personal Medical Liaison to Help Transition Between Hospital and Home

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It has been said that the creative destruction of the current hospital and health system model has begun.[1] Now, with new incentives for preventive care and novel concepts like the medical home model, there is immense pressure for health systems to change the way they will function in the future.

Our current hospital care model is based on the healthcare service demands of the past, when infectious diseases and childbirth were among the major causes of mortality and the general population did not live long enough for chronic medical conditions to progress to the point where patients needed the complex care provided by a hospital. This care model, combined with the evolution of payment for services rendered, created the current acute care fee-for-service method of reimbursement. With the general population living longer and proliferation of illnesses with partial environmental triggers (eg, cancer), the current model of care is no longer the most efficient or the most effective one for the conveyance of medical care.

Healthcare as an industry has been quite intransigent in moving to a newer model for care. This is in part due to lack of incentives (or penalties) encouraging change, along with the demands of society and the "cabal" of medical practitioners.[2] Currently, we are approaching a tipping point of penalties and incentives, primarily due to the Affordable Care Act, that will move us to create a more modern model for the delivery of healthcare.

The changes will benefit society as well as the healthcare industry in the long run. In the short run, however, this chaotic period of change will leave patients in a vulnerable position. The type of care they need and the type of care they are likely to receive (no matter the quality) are not likely to be the same until the system sorts itself out. During this period of flux, there is a need and an opportunity for services that will bridge the gap between past and future paradigms for healthcare delivery.

Until a new model emerges, one of the most difficult barriers to good patient outcomes is the transition between different levels and venues of care.[3,4] There is new impetus to create a reliable and effective means to shepherd patients through the transition between inpatient hospitalization and the immediate post hospitalization return to their normal living environment. This includes moving to a more complex self-care regimen in the ambulatory setting, secondary to the development or progression of chronic medical conditions.

Issues concerning poor transitions of care are not new. A great deal of literature exists about poor outcomes and readmissions related to medication compliance, wound care, and follow-up with a patient's primary care provider.[5,6]

Some attempts have been made by health systems to address transitional issues with methods such as post discharge phone calls[5] and expanded case management and discharge planning. The problem inherent in this approach is that there is no long-term incentive for a health system that is paid for acute care to provide these services on an ongoing basis. Services such as case management have a specific goal: to assist patients with their return home by helping with logistics, setting up services such as home care, or assisting with obtaining durable medical equipment. Helping with logistics is not the same as helping with disease management. The primary goal of aid with logistics is to prevent patient readmission within 30 days of discharge to avoid the penalties associated with value-based purchasing.

These attempts may help to address issues such as poor discharge education and the proliferation of so-called "frequent flyers" in health systems, but there is no mechanism that would make it financially beneficial to

extend acute care services to a chronic care model[7] providing long-term support for such patients. A review of the literature shows that while most health systems want to avoid immediate readmissions, many are struggling to be effective in this area.[8] As hospitals figure out how to approach this problem, who is paying for experimentation with and development of systems that are in accord with value-based payment models? In our current model, it is managed care payers.

I believe the time has come for managed care payers to take an even more active role in the care of their hospitalized members. Let me pause to state that I do not advocate payers building or running their own hospitals. The health maintenance organizations of the 1980s and 1990s amply demonstrated the difficulties inherent in such a model. However, I do advocate that payers create the means for having a presence in hospitals where their members are receiving care.

I suggest the creation of a personal medical liaison (PML). This would be an individual with medical training (eg, RN, PharmD) and experience in the hospital setting. This hospital experience is crucial because without it the PML would not be able to gain credibility and trust with hospital personnel and would not be able to predict and head off the common pitfalls that make the transition from acute care to recuperation at home such a vulnerable period for patients.

The PML would meet with the patient and his or her representative before discharge and review the course of the hospital stay, assist with the patient being signed out from the charge nurse, and review the hospital records. The PML would receive copies of all discharge documentation and would help case management personnel with issues related to discharge planning (eg, home care, follow-up appointments with primary care physicians). The PML then would circle back to the patient at home or the equivalent (ie, rehabilitation or skilled nursing facility) and make sure there are no gaps in discharge education and that any new prescriptions have been filled. This individual would also be available to the patient for any questions or concerns he or she might have.

The PML could develop an ongoing relationship with the patient, wherein he or she would be available for a period of time or on a continuing basis, depending on the complexity of the disease states, the level of compliance of the patient, and the resources needed. For example, for the patient with congestive heart failure, hypertension, or type 2 diabetes mellitus, the PML would check in monthly at the patient's home to make sure there are no barriers to compliance and that any new issues are identified and brought to the appropriate doctor's attention before the problems escalate to the point where another inpatient admission is needed. For patients who are compliant and whose disease states are well controlled, the PML would only need to check in quarterly.

With the advances in predictive modeling and the wealth of patient information now available, it could be a relatively straightforward exercise to create a predictive algorithm able to forecast the cost of a patient's care for the next 5 years. Those health plan members whose predicted costs are in the top 10% would automatically be assigned a PML. This would allow payers to take a direct hand in controlling the care and its associated costs for their members during these vulnerable transitions of care.

The PML contract should include a reasonable target for hospitalizations avoided, errors prevented, or costs avoided. The PMLs would be paid on a per patient basis and evaluated annually on their acuity in managing patients and on their ability to save costs for the managed care payer. Because use of PMLs would also benefit the hospitals involved by preventing unnecessary 30-day readmissions, there should be some cost sharing between the facility and the payer, which could be a part of rate negotiation between these parties. This cost split could be a model for helping to prevent short-term readmissions, and the savings could be used to subsidize long-term preventive care and disease management. Personal medical liaisons would also help to bridge the transition between our current model of healthcare delivery and the one to come.

There will probably be some resistance from hospitals to the PML model. One area of concern might be in sharing current patient records with an individual representing the payer, which could be construed as creating additional risk of reporting errors or issues that might trigger an audit by the payer. Having the PML as an independent contractor jointly hired by the hospital and payer could overcome this concern and might mitigate any liability exposure for the hospital.

There are numerous advantages to having a third-party PML to ensure more effective transitions of care. For the hospital there could be fewer readmissions, as well as the opportunity to prevent more costly care in the future. For the payer it would create a mechanism for more efficient management of resources geared toward outpatient preventive care. Use of a third-party PML is more difficult to administer and manage, but it is inherently cheaper than inpatient care and is more cost-effective in the long run. For the patient, a new resource would be available that has the sole purpose of helping to keep his or her

disease state controlled, as well as assisting with obtaining future medical care. Those patients who are newly diagnosed with a chronic condition may find the PML's services to be particularly helpful and effective. Right after diagnosis and early in the progression of the disease, there is time to make important interventions that can prevent long-term effects that are both difficult for the patient to endure. A PML who can assist with disease education, demonstrate appropriate self-care, and ensure compliance with medications could have a tremendous impact on a patient's life.

The PMLs would also create a significant differentiating factor for the payers contracting with them. A medical professional who knows the patient well, can make house calls, and is available to help educate the patient about his or her disease states is invaluable. Furthermore, integration of disease management into patients' daily lives (instead of the disease taking over and ruling their lives) is a powerful marketing tool for the health plan. The patient loyalty engendered by this relationship could be profound.

In summary, the PML model would provide 3 main benefits. First, it would decrease the risk of unnecessary readmission to the hospital within 30 days. Hospitals have shown themselves to be unable to address this issue on their own. Second, it would generally improve patient outcomes, which would decrease the total cost of the illness for the managed care organization. Third, it would provide a significant differentiating factor from other managed care organizations as a customer service that engenders member loyalty as well as providing a marketing tool to secure greater market share.

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